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8 **BEFORE THE**
BOARD OF REGISTERED NURSING
9 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

10 In the Matter of the Accusation Against:

11 **SANDHYA SHETTY**
12 **3861 Mentone Ave. #25**
13 **Culver City, CA 90232**

14 **Registered Nurse License No. 678691**

15 Respondent.

Case No. **2010-287**

A C C U S A T I O N

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17 Complainant alleges:

18 **PARTIES**

19 1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her
20 official capacity as the Interim Executive Officer of the Board of Registered Nursing (Board),
21 Department of Consumer Affairs.

22 2. On or about May 3, 2006, the Board issued Registered Nurse License Number
23 678691 to Sandhya Shetty (Respondent). The Registered Nurse License was in full force and
24 effect at all times relevant to the charges brought herein and will expire on July 31, 2011, unless
25 renewed.

26 **JURISDICTION**

27 3. This Accusation is brought before the Board under the authority of the following
28 laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

4. Code section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

6. Code section 2761 states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

7. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

8. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

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9. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

COST RECOVERY PROVISION

10. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

1 **DRUG DEFINITION**

2 11. Heparin Flush IV is an anticoagulant used to keep intravenous (IV) catheters open
3 and flowing freely. Heparin helps to keep blood flowing smoothly and from clotting in the
4 catheter by making an anti-clotting protein in the body work better.

5 **SUMMARY OF FACTS**

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7 12. Since about May 2006, Respondent was employed as a registered nurse in the
8 Pediatrics Unit (4NE) at Cedars-Sinai Medical Center (CSMC), Los Angeles. On or about
9 November 18, 2007, while working the night shift (7 p.m. to 7 a.m.), Respondent was assigned to
10 cross-train¹ with Nurse Eva Bedford-Oppong (Nurse Bedford-Oppong) in the Pediatrics Unit
11 (4NE). Their patients included twins, Patient #1 and Patient #2, who were housed in the same
12 room. Patient #1 was a 9-day old female infant admitted to 4NE on November 17, 2007 with a
13 rash. Physician's order was for Acyclovir every 8 hours IV, and Vancomycin every 8 hours IV.
14 Patient #2 was a 9-day old male infant admitted to 4NE on November 17, 2007 with a rash.
15 Physician's order was for Acyclovir every 8 hours IV, and Vancomycin every 8 hours IV. Per
16 hospital protocol, Heparin Flush 10 units per milliliter is to be administered after the
17 administration of IV medications.

18 13. At about 1900 hours, upon assessing Patients #1 and #2, who were still receiving IV
19 medications started by the outgoing nurse, Valerie Bugnon, Respondent noticed that both patients
20 had slight bleeding from their IV sites and/or heel sticks. During her assessment, Respondent
21 heard either Patient #1 or #2's pump sound, indicating that the IV medication was completely
22 infused. Respondent turned off the pump and went to the medication room with Nurse Bedford-
23 Oppong to obtain a Heparin flush dose. Respondent did not verify the vial to assure the correct
24 dose of the Heparin flush, but noticed the vial had a green top.

25 14. At about 1915 hours, while Respondent was preparing the flush, Charge Nurse
26 Kristen Voelker (Charge Nurse Voelker) informed Respondent that the IV medication on the

27 ¹ Cross-train consists of shadowing the primary nurse to become familiar with the routine
28 functions and procedures in that unit.

1 other patient was also completed. Charge Nurse Voelker then prepared the other Heparin dose
2 and handed the syringe to Respondent. Respondent handed one of the prepared syringes to Nurse
3 Bedford-Oppong to be used on Patient #2, while Respondent used the other syringe on Patient #1.

4 15. Between 1915 to 1945 hours, Respondent administered a Heparin Flush on Patient
5 #1, while Nurse Bedford-Oppong administered a Heparin Flush on Patient #2.

6 16. At 1945 hours, Respondent documented in the nursing notes the following:

7 Patient #1: "Heparin was drawn by Kristen Voelker & given by me (Sandya)"

8 Patient #2: "Heparin flush given per protocol after antibx. SS."

9 17. At about 2115 hours, after having noticed more oozing of blood from Patients #1 and
10 #2's IV sites, Respondent notified Charge Nurse Voelker and the treating physician.

11 18. At 2240 hours, the Heparin drawer was discovered to contain Heparin vials 10,000
12 units per milliliter. Laboratory tests conducted that day revealed that Patients #1 and #2 were
13 overdosed with Heparin. On November 19, 2007, two doses of a Heparin reversal antidote,
14 Protamine Sulfate 25mg, were administered to both patients.

15 **FIRST CAUSE FOR DISCIPLINE**

16 **(Gross Negligence)**

17 19. Respondent is subject to discipline under Code section 2761, subdivision (a)(1) on the
18 grounds of unprofessional conduct as defined under California Code of Regulations, title 16,
19 section 1442, in that on or about November 18, 2007, while on duty as a registered nurse at 4NE
20 at CSMC, Respondent was grossly negligent in the following respects:

21 a. Patient #1 or Patient #2. At about 1915 hours, Respondent drew up a Heparin Flush
22 solution into a syringe and could not recall if she had checked the vial for the correct
23 medication, concentration or expiration date. Complainant refers to and incorporates all
24 the allegations contained in paragraphs 12 - 18, as though set forth fully.

25 b. Patient #2. At about 1945 hours, Respondent gave a prepared Heparin Flush syringe to
26 Nurse Bedford-Oppong to administer, but did not verify the correct medication,
27 concentration, route or absence of discoloration or particulate matter with Nurse
28

1 Bedford-Oppong. Complainant refers to and incorporates all the allegations contained
2 in paragraphs 12 - 18, as though set forth fully.

- 3 c. Patient #1. At about 1945 hours, Respondent took a syringe prepared by Charge Nurse
4 Voelker and flushed this patient's IV line, but did not verify the correct medication,
5 concentration, route or absence of discoloration or particulate matter with Charge Nurse
6 Voelker.

7 **SECOND CAUSE FOR DISCIPLINE**

8 **(Incompetence)**

9 20. Respondent is subject to discipline under Code section 2761, subdivision (a)(1) on the
10 grounds of unprofessional conduct as defined under California Code of Regulations, title 16,
11 sections 1443 and 1443.5, in that on or about November 18, 2007, while on duty as a registered
12 nurse at 4NE at CSMC, Respondent was incompetent in the following respects:

- 13 a. Patient #2. At about 1945 hours, Respondent gave a Heparin flush syringe to Nurse
14 Bedford-Oppong to administer but did not document who prepared the syringe.
15 Complainant refers to and incorporates all the allegations contained in paragraphs 12 -
16 18, as though set forth fully.
- 17 b. Patient #2. At about 1945 hours, Respondent failed to document in the nursing notes
18 that Nurse Bedford-Oppong administered the Heparin flush. Complainant refers to and
19 incorporates all the allegations contained in paragraphs 12 - 18, as though set forth
20 fully.

21 **PRAYER**

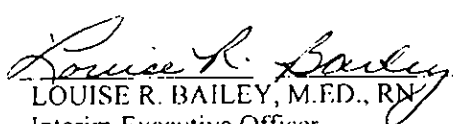
22 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
23 and that following the hearing, the Board of Registered Nursing issue a decision:

- 24 1. Revoking or suspending Registered Nurse License Number 678691, issued to
25 Sandhya Shetty;
- 26 2. Ordering Sandhya Shetty to pay the Board of Registered Nursing the reasonable costs
27 of the investigation and enforcement of this case, pursuant to Business and Professions Code
28 section 125.3;

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3. Taking such other and further action as deemed necessary and proper.

DATED: 12/7/09


LOUISE R. BAILEY, M.Ed., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant